

Personal & Family Health History

Please check all that apply:	Self	Family	Comment
Asthma/allergies			
Eczema			
Psoriasis			
Acne			
Skin cancer			
Keloids (raised scars)			
Fevers			
Weight loss			
Eye problems			
Ear, nose, throat problems			
High blood pressure			
Heart condition			
Respiratory (breathing) problems			
Stomach or intestinal problems			
Hepatitis			
Arthritis			
Neurological problems			
Psychiatric conditions			
Diabetes			
Menstrual irregularities			
History of excessive bleeding			
Anemia			
Cancer			
Urinary problems			

List all medications (internal & topical) currently used within the past seven days, including aspirin, tranquilizers, pain pills, etc.

Are you allergic to any medications? _____

Do you have problems with local anesthetics? _____

Are you on blood thinning medications? _____

Do you require antibiotics prior to surgery? _____